

If limitations are advised, please specify those limitations:

If this child has any physical, developmental or behavioral problems, how can the school assist with special programs, placement or attention?

Medications:

If this child is taking any medication, please list medication and reason for taking:

Medication	Reason for taking

Immunizations: Ohio Law describes minimum requirements for school entrance.
Separate print-out from doctor's office with the needed information is acceptable.
Please staple to back of this form.

Type:	Record Month/Day/Year
DTaP, DPT, DT	_____
Td, TDaP	_____
Polio, OPV, IPV	_____
MMR	_____
Hepatitis B	_____
Varivax (chickenpox)	_____ (date of vaccine or disease)
HIB	_____
Plevnar (pneumococcal)	_____ Recommended.
TB Test	_____ Result: Neg. _____ or Pos. _____ Optional
Other	_____

Please print or stamp (Required):

Doctor's name	Doctor's signature
Address	Date signed
Phone	